The US Global Health Initiative
Informing Policy With Evidence

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THE US APPROACH TO GLOBAL HEALTH IS CHANGING in ways that present an enormous opportunity to understand the link between foreign assistance and health. In May 2009, the Obama Administration unveiled a 6-year $63 billion Global Health Initiative (GHI),[1] increasing its commitment to supporting health care in the world's poorest countries during tight budgetary times. The initiative aims to consolidate many of the existing programs in an effort to improve coordination of the current structure that uses multiple government agencies and programs. The core principles reveal several departures from the past decade's approaches that include implementing new women-centered and girl-centered approaches; strengthening health care systems; increasing support to multilateral organizations such as the GAVI Alliance (formerly The Global Alliance for Vaccines and Immunisation) and the Global Fund; and encouraging country ownership of health care plans.[2]

The initiative's funding priorities have shifted toward greater funding for programs that target primary health care delivery and less funding for providing antiretroviral therapy. These represent a major change in direction from the past decade's focused investment on disease-specific programs such as the President's Emergency Plan for AIDS Relief (PEPFAR) and the President's Malaria Initiative in an ambitious approach to tackle broader structural challenges in service delivery. In the past, however, the relationship between development assistance and broad, transformative change in international development, particularly in Africa, has been spotty and is poorly understood.[3] That experience could inform the GHI.

The initiative's new goals are laudable in many ways. The focus on primary health care for women and children, health system strengthening, and country ownership is a necessary step in building a future in which local health systems are capable of providing sustainable health care services. Sustainability and ownership were minor considerations in the US government's approach to health assistance in the past decade: PEPFAR was established in response to the steamrolling tragedy of human immunodeficiency virus (HIV)/AIDS across many African countries using massive investments and third-party implementers. Now that HIV prevalence rates are stabilizing across much of the continent, PEPFAR is evolving to reflect the values of the new initiative: away from an emergency response and toward strengthening partner government capacity to provide HIV care and integration of HIV programs with broader global health objectives.[4]

Large investments in global health are a relatively new phenomenon in the world of foreign assistance, rising to prominence in the past decade. However, economic development assistance has a history that spans decades and its lessons suggest a cautionary tale for the initiative's revised approach. A recent assessment grouped development assistance efforts into 2 broad categories: transformational approaches that aim to achieve large, permanent improvements in broad social and economic indicators; and marginal approaches that attempt to solve a specific problem for a targeted group of beneficiaries. The logic behind the transformational approach is that a sufficiently large assistance program will help recipient countries trapped in a self-sustaining cycle of poverty get on course for sustainable development. Numerous studies have failed to link foreign assistance with comprehensive economic development; in fact, in some accounts, countries that received the most aid have seen the least growth.[5] This history highlights the need to evaluate aid programs more rigorously, especially in a political climate that stresses accountability for an effect with taxpayers' dollars. The parallels with foreign assistance for health are inexact but important. PEPFAR was originally tasked with addressing a specific problem, and by many accounts has been successful. The GHI, although still vague in scope, shares characteristics with transformational aid by targeting large structural changes in recipient countries. The checkered history of foreign aid has led to skepticism about aid as a tool for transformational economic development, which is important to heed as the GHI is launched.

There is little doubt that aid can work, but there is considerable uncertainty about how to make it work. The ap-

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proaches to providing aid in a way that will improve maternal and child health in poor countries are poorly understood—what political and economic conditions are auspicious? Which implementation strategies work? What incentives promote effective use of aid dollars? The barriers are not technological: interventions with enormous health benefits such as insecticide-treated bed nets, condoms, and oral rehydration solutions exist. The challenge is how to transform dollars into effective programs. Although the US government's resource allocation in global health over the past 5 years has drawn criticism over the disproportionate emphasis on singular causes and unsustainable approaches,[6] PEPFAR generated useful lessons and significant goodwill. One way the GHI will be assessed is by whether it has learned from some of PEPFAR's successes and maintained the enthusiasm generated by it to prevent skepticism that may endanger future support for global health activities.

This challenge for the GHI is also an unusual opportunity to generate new knowledge on the effectiveness of foreign aid generally and for health improvement in particular. The current stage of the initiative, a major shift in strategy using approaches with unknown effectiveness, presents a rare prospective opportunity for determining how to make the best use of earmarked resources. New approaches to delivering aid, such as results-based financing, hold promise as potentially effective tools that circumvent perennial pitfalls such as misunderstanding local incentives and failure to encourage local innovation in service delivery. New methods for evaluating aid programs using randomized experiments are gaining momentum. From cluster-randomized implementation of universal health insurance in Mexico[7] to the estimation of health and educational benefits of treating Kenyan schoolchildren for intestinal parasites,[8] randomized trials studying the health consequences of aid and policy programs are increasingly common. The 2010 John Bates Clark medal, economics' "baby Nobel," was awarded to a development economics experimentalist,[9] further increasing the visibility and acceptability of these approaches. Despite many objections to experimenting with policy implementation (eg, is it ethical to charge for bed nets in one district when they are fully subsidized in another?), the lack of understanding of where and how development assistance may promote health makes it a key responsibility to invest in understanding the process that leads from Washington's coffers to reduced child mortality.

This revised commitment to global health will set the United States on an ambitious path to improve health outcomes in many of the world's most needy areas. The opportunity to inform future policy with experimental evidence can make the GHI a pillar of action as well as learning.

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